

# **14<sup>th</sup> Amendment Guarantee of Due Process:**

**CMS Final Rule on MCO Grievances and Appeals CFR 438, Subpart F**

**NC Division of Medical Assistance**

**July 2017**

# CMS Final Rule on MCO Grievances and Appeals

- CFR 438, Subpart F
  - Strengthens and protects rights of the Medicaid Beneficiary
  - Drives Accountability of MCOs and State Medicaid Agency in the New World of ‘Super Waivers’
  - Aligns Medicare and Medicaid timelines

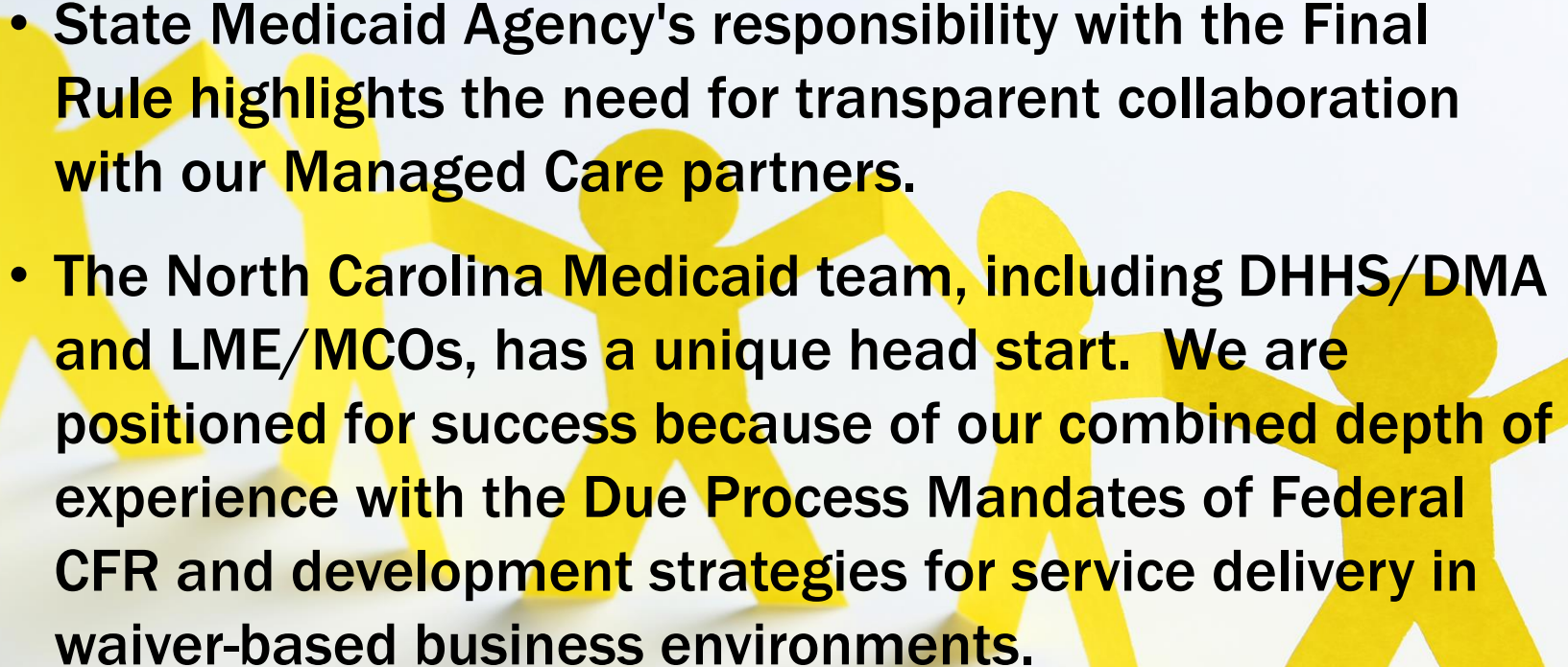


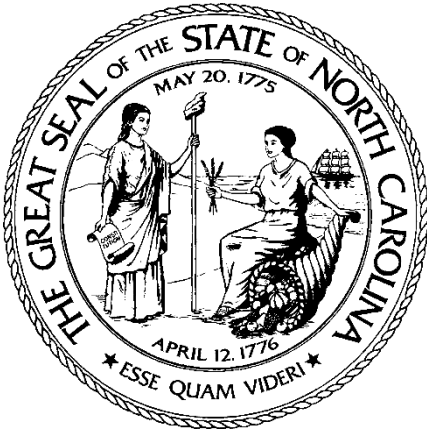
# **CMS Final Rule on MCO Grievances and Appeals**

**Following study into business practices of MCOs in waiver environments, CMS chose to more clearly define the role of Due Process for Medicaid beneficiaries in order to:**

- Modernize the Medicaid managed care procedures**
- Protect the beneficiary when the MCO issues decision of adverse determination**
- Emphasize the role of the state Medicaid agency as responsible entity for assurance of the uniform protection of Federal Due Process Statute and regulation**

# CMS Final Rule on Grievances and Appeals

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- State Medicaid Agency's responsibility with the Final Rule highlights the need for transparent collaboration with our Managed Care partners.
  - The North Carolina Medicaid team, including DHHS/DMA and LME/MCOs, has a unique head start. We are positioned for success because of our combined depth of experience with the Due Process Mandates of Federal CFR and development strategies for service delivery in waiver-based business environments.



# **CMS Final Rule on MCO Grievances and Appeals CFR 438, Subpart F: Highlights**

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# CMS Final Rule on MCO Grievances and Appeals

- Oral Appeal Requests
  - Beneficiaries will be allowed to request an internal appeal from the MCO/PHP/PAHP by making a phone call request
  - Protections must be in place for oral appeals to ensure that the appeal is acknowledged and the resolution timeframe runs from the date the oral appeal is received by the managed care plan
  - LMEs should have a method for acknowledgement of receipt of the oral appeal in writing, along with its date of receipt



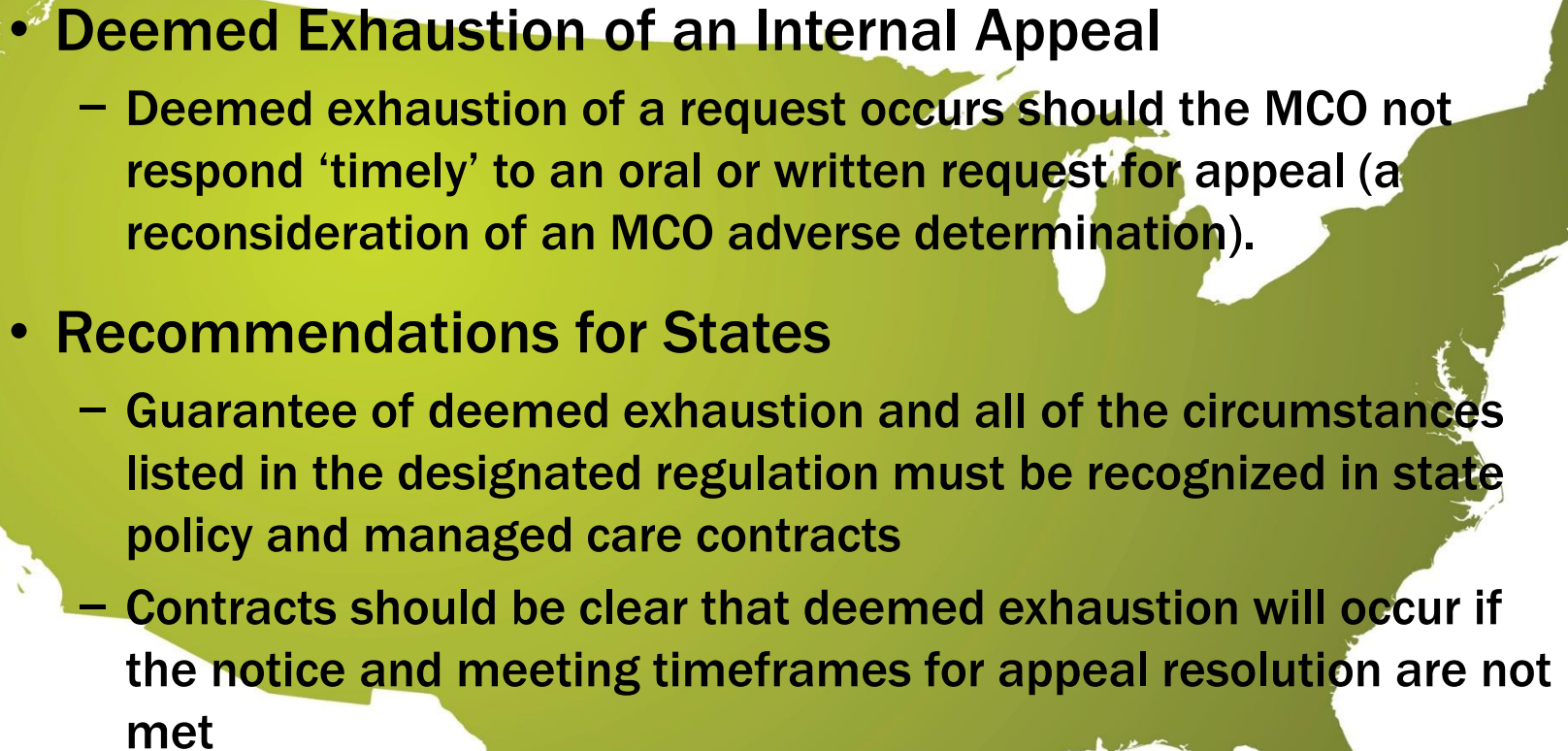
# CMS Final Rule on MCO Grievances and Appeals

## Timeliness of Requests for Appeal

- There can only be one level of appeal;
- Enrollees must exhaust that appeal before requesting a state fair hearing;
- The enrollee must file the appeal within 60 calendar days from the date of the Adverse Benefit Determination Notice;
- If the MCO, PIHP, or PAHP fails to adhere to the “notice and timing requirements” contained in §438.408, the enrollee is deemed to have exhausted the in-plan appeal process and can immediately request an impartial state fair hearing



# CMS Final Rule on MCO Grievances and Appeals

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- **Deemed Exhaustion of an Internal Appeal**
    - Deemed exhaustion of a request occurs should the MCO not respond ‘timely’ to an oral or written request for appeal (a reconsideration of an MCO adverse determination).
  - **Recommendations for States**
    - Guarantee of deemed exhaustion and all of the circumstances listed in the designated regulation must be recognized in state policy and managed care contracts
    - Contracts should be clear that deemed exhaustion will occur if the notice and meeting timeframes for appeal resolution are not met



# CMS Final Rule on MCO Grievances and Appeals

## Deemed Exhaustion: Fine Points to Consider

Remember, the enrollee is not before an impartial reviewer during the in-plan appeal. This makes 'deemed exhaustion' an area of visibility. Compliance with federal Right of Due Process requires that the MCO always provide, in the Letter of Adverse Determination:

- Notice of appeal rights or rights to continued benefits
- Notices written at an appropriate reading level
- Notices with Translation options for enrollees who speak languages other than English
- Notices mailed timely
- Notices with specific reasons for an adverse determination that relate policy to request for service and to clinical information received





# CMS Final Rule on MCO Grievances and Appeals

## Designees as Representative for Beneficiaries in Appeals

- If states allow, the provider can be designated as representative
- North Carolina currently allows a 'representative' to be chosen, and that choice is made on filing of the formal appeal request.
- Final Rule allows 'written designation' of a representative, but separates the designation from the filing of the appeal request or formal fair hearing request.
- The new rule indicates that the designation may occur prior to an appeal process being initiated.

# CMS Final Rule on MCO Grievances and Appeals

## Use of Standardized Templates for Notices to Beneficiaries

- All MCOs, PHPs, and PAHPs should be required to develop and use notice templates and to obtain pre-clearance from the state prior to first use;
- The templates should be publicly available
- Remember, North Carolina Medicaid has been developing uniform templates in satisfaction of its previous Settlement stipulations, and all state vendors, including LME/MCOs use them





# CMS Final Rule on MCO Grievances and Appeals

## Processes for Appropriate Reviewers

MCOs, PIHPs, and PAHPs must have a process for handling grievances and appeals that:

- Ensures that the arbiter of the decision on the grievance or appeal was neither involved in a previous level of review nor a subordinate of someone involved in deciding the previous level of review
- If the appeal involves denial based on *medical necessity*, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal that involves clinical issues, the reviewer must have “***appropriate clinical expertise***, as determined by the State, in treating the enrollee’s condition or disease.”





# CMS Final Rule on MCO Grievances and Appeals

## Request for Appeals Now Separate from Requests for ‘Continuation of Benefits’

- The beneficiary must request their ‘continuation of benefits’ at least 10 days before the expiration of their current authorization
- For ***Fee for Service*** Medicaid, the beneficiary shows evidence of request by ‘timely’ submission of an appeals request to OAH in response to an adverse determination
- Final Rule indicates separate processes for request of a ‘benefit continuation’ during an appeal and for requests of MCO level appeals and ‘formal fair hearings’.



# CMS Final Rule on MCO Grievances and Appeals

## **The Importance of Careful Application of Principles of Due Process to ‘Continuation of Benefits’**

The Supreme Court has decided that:

- Low-income people have a “brutal need” for continued benefits pending appeal
- The need rises to the level of a constitutional protection

Please see NHeLP brief #2, at:

[http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg#.WXib5\\_nyu01](http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg#.WXib5_nyu01)



# CMS Final Rule on MCO Grievances and Appeals



- States will follow federally established timeframes for resolution:
  - Grievances: Within 90 calendar days from the day the health plan receives the grievance
  - Standard Appeals: Within 30 calendar days from the day the health plan receives that appeal, unless extended
  - Expedited Appeals: Within 72 hours after the Health Plan receives that appeal, unless extended
- Timeframes can be extended by and up to 14 calendar days if:
  - The enrollee requests it, or;
  - If the MCO, PIHP, or PAHP shows to the satisfaction of the state agency that there is a need for additional information and how the extension *is in the enrollee's interest*

# CMS Final Rule on MCO Grievances and Appeals

## State Responsibilities for Monitoring/Oversight

- Entities must maintain records of grievances and appeals
  - States must review the information as part of ongoing monitoring
- The records must be accessible to the state, available upon request to CMS and must, at a minimum, contain:
  - A general description of the reason for the appeal or grievance
  - Date received
  - Date of review
  - Resolution
  - Date of resolution
  - Name of enrollee for whom the appeal or grievance was filed





# CMS Final Rule on MCO Grievances and Appeals

## State Responsibilities for Monitoring/Oversight

- The State Medicaid Agency should be prepared for full public disclosure of grievances and appeals, including...
- Annual reports that include numbers and subject matter of grievances and appeals on an aggregate and plan level
- By plan, the number or times the standard timeframe for resolution was extended, not at the request of the enrollee
- The number of times that requests for expedited reviews were denied, along with the subject matter of the request

